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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

PHYSICIAN ASSISTANT APPLICATION FOR PRESCRIPTIVE AUTHORITY

PLEASE TYPE OR PRINT ALL INFORMATION. INCOMPLETE APPLICATIONS WILL BE RETURNED.

SECTION A:

I am applying for Controlled _____ Non-Controlled _____ Prescriptive Authority in the State of Delaware.

Please provide your Delaware Physician Assistant license number C5-_____

_____I am applying for a Delaware Physician's Assistant license.

_____I am submitting this application due to a change in my supervising physician(s).

This form must be completed for each business/facility where the Physician's Assistant will be practicing.

SECTION B: PERSONAL INFORMATION

_____

Last Name First Name MI

_____

Street/P.O. Box Apartment #

City _____ State _____ Zip _____

Home Telephone: _____ E-mail Address: _____

Cell Phone: _____

Name of Business/Practice:_____

Business/Facility Address: _____

Business Telephone: _____Email: _____

SECTION C: CONTROLLED PRESCRIPTIVE AUTHORITY - This section must be completed by the supervising physician for each physician assistant who is applying for Controlled Prescriptive Authority. This page may be duplicated and completed to include additional supervising physician(s) in your practice. If this form is duplicated, please attach to the application.

_____ _____

Name of Supervising Physician (Print Legibly) Specialty

_____ _____ _____

Delaware Physician License Number Federal DEA Number Delaware DEA Number

I, _____ can prescribe the following schedules:
Name of supervising physician (Print Legibly)

Schedule II, III, IV, V ____, Schedule III, IV, V ____, Schedule IV, V ____, Schedule V _____

The Physician Assistant identified on this form in Section B is authorized to prescribe controlled substances under my supervision for the following schedules:

Schedule II, III, IV, V ____, Schedule III, IV, V ____, Schedule IV, V ____, Schedule V _____

The Physician Assistant identified in Section B may request and issue professional samples of controlled legend medications. I am delegating this authority. Yes _____ No _____

Please list the number of Physician Assistants you are currently supervising: _____

_____ _____

Signature of Supervising Physician Date

SECTION D: CERTIFICATION

By signing this form, the physician assistant and the supervising physician (if appropriate) agree that the above information is true and accurate and that the physician assistant or the supervising physician shall promptly by submitting a new application for Prescriptive Authority to notify the Board of Medical Practice of all changes of supervising physician(s) and schedule(s) authorized.

_____ _____

Signature of Applicant Date